NOTICE OF INDEPENDENT REVIEW DECISION

April 3, 2003

RE: MDR Tracking #: M2-03-0408-01
IRO Certificate #: IRO4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in neurosurgery which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work-related injury on ___ when he was lifting a box down from a shelf and fell backwards landing on his buttocks. The patient complained of low back pain and a CT scan performed on 04/18/01 was reported as normal. An MRI performed on 10/20/99 was interpreted as facet hypertrophic changes and congenitally short pedicles with lateral recess narrowing at L4-5 and minimal disc bulges at L5-S1. Additional diagnostic studies were ordered and the patient was placed in physical therapy and given systemic steroids as an anti-inflammatory drug followed by non-steroidal anti-inflammatory medication and Hydrocodone. On 07/12/02 an electromyogram was interpreted as abnormal indicating a bilateral L4 radiculopathy and a radiculopathy of the second nerve root on the left. On 09/20/02 a myelogram and subsequent CT scan with contrast material in place was felt to be insensitive at the L5-S1 level due to a thick epidural fat pad. However, a 1 to 2mm disc protrusion at L5-S1 and at L4-5, left foraminal disc protrusion, which could just reach the exiting left L4 nerve root was identified.

Requested Service(s)

Discogram with CT scan

Decision

It is determined that the discogram with CT scan is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has had progressively worsening symptoms since ___ and has not improved despite conservative management. Neurological and orthopedic examinations are consistent with lumbar radiculopathy at an uncertain level. Electrodiagnostic studies and myelogram/CT were compatible but not absolutely diagnostic of lumbar radiculopathy, at a level that could not be determined. A lumbar discogram is indicated to determine which lumbar nerve root or roots are symptomatic. Given the complexity and progressive worsening of this patient's symptomatology, this lumbar discogram is a prudent diagnostic recommendation. Therefore, the discogram with CT scan is medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,

In accordance with Commission Rule 102.4 (h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 3rd day of April 2003.